VOL. 13, NO. 3 SEPT.-OCT., 1963

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

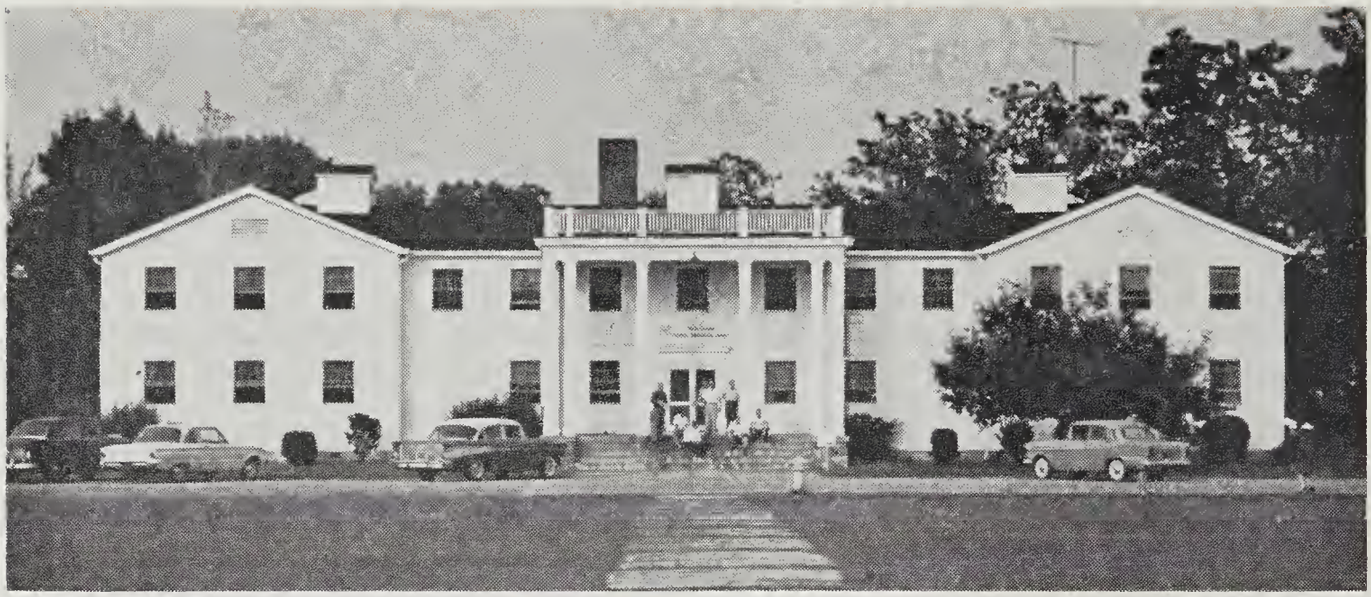
TREATMENT

REHABILITATION

EDUCATION

PREVENTION

N. C. ALCOHOLIC REHABILITATION CENTER



BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The Center is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Department of Mental Health. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay if the patient is able to pay.

Butner Treatment Methods

Treatment at the Center is by psychotherapy and consists of group discussions led by the professional staff, educational films, individual consultations with staff members, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the medical director, a psychiatric social worker, a chaplain and admitting officer, a vocational rehabilitation counselor, an activities director, and a full attendant staff.

The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment in response to written or telephone request to the Medical Director of the Center, 406 Central Avenue, Butner, N. C., expressing voluntary desire for treatment. All appointments must be confirmed by mail and should preferably be made by the patient's physician or by other professional personnel in the patient's community, for example, alcoholism information center personnel.

2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Service Agency, and a complete medical history, compiled by the patient's family physician, are necessary.

3. A fee of $75, in cash or certified check, must be paid upon admission if the patient is able.

4. Sign a letter-statement requesting voluntary admission at the time of admission.

It is especially important that patients applying for admission have a thorough medical examination and be in good physical condition at the time of their admission. The Center is not a hospital or a sobering up facility and patients desiring admission should have been sober for at least seventy-two hours and should not be exhibiting withdrawal symptoms. There are no facilities provided at the Center for the treatment of physical illness. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Admitting Hours

Wednesday, Thursday and Friday during the morning and afternoon. Patients may have visitors after they've been at the Center for 2 weeks. Visiting hours are from 1:00 - 4:00 P. M. on Saturday and Sunday.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA DEPARTMENT OF MENTAL HEALTH

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RALEIGH, N. C.

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Medical and Psychiatric Aspects of the Homeless Alcoholic

BY NORMAN A. DESROSIERS, M.D.
MEDICAL DIRECTOR,
N. C. ALCOHOLIC REHABILITATION CENTER
BUTNER, N. C.

"THE Medical and Psychiatric Aspects of the Homeless Alcoholic" is a particularly difficult subject to discuss because, to my knowledge, there is very little written about the subject to delve into. In approaching problems like this, for example, alcoholism itself, or homelessness itself, you have to be particularly careful not to segment your study of it. Entirely wrong conclusions are apt to be drawn when you get too narrow in your approach to the study of human behavior. A particularly careful attempt will be made to avoid that trap in this discussion.

Rather than talk about the person who is "homeless", which is a sociologic definition, or the "alcoholic," which is an eponym that has just sort of risen by common usage, it will probably be more useful to trace the historic development of a real live person, flesh and blood, who appears to have literally become a "homeless alcoholic." Appropriate interpretations of a medical, psychologic, or sociologic nature can then be made during the course of tracing this historical development.

Let us begin by re-emphasizing the fact that the word "alcoholic" itself has become an almost meaningless term. At best it is an epithet of moral derision applied to persons who, for a multitude of reasons, exhibit a common symptom of addiction to the chemical substance, alcohol. The usual derisive use of the term as applied to a person with a drinking problem is in marked contrast to society's designation of persons addicted to other chemical substances such as heroin, morphine, peyote, or barbiturates. They are not called "heroics", or "morphics", or peyotics" or "barbiturics." This discussion shall, then, take the person who is dubbed or pigeon-holed as "homeless" and "alcoholic" and attempt to show how he came to exhibit these symptoms. It should be remembered also that symptoms represent the manifestations of some underlying cause and don't constitute the entire cause.

Mr. A. is an actual person who was referred to the Center by appointment. He came, however, even after careful instruction over the phone, without the required general physical workup. The first time I saw him he was sitting on the couch. I glanced at him as I walked by, as is the custom in such circumstances, but, after a few steps, I had to stop and go back to take a second look.

A psychiatrist discusses the case history of a homeless alcoholic who was a patient at the N. C. Alcoholic Rehabilitation Center at Butner.

This address, published by permission of the author, was delivered at a statewide institute on the "Homeless Alcoholic in North Carolina" in Raleigh last February 13 and 14.

He was unshaven, unkempt, and yet not an unattractive looking man. He was tall, slender and, it was discovered, 42 years old. He had been drinking heavily, and had really come from what could be called a flop house. He appeared very sick, very shaky, and obviously had lost a lot of weight. Since the Center is not designed for the treatment of medical problems requiring bed and nursing care, he could not be admitted.

Through the good offices of our AA contacts it was possible to get him back to the city of his referral. The referring agency was called with specific instructions given that the man be hospitalized and given immediate necessary medical care. It was felt the patient in this situation was handled right. He was provided transportation. Medical care, which we had trusted would be effected, was waiting for him. But as we later discovered, to our chagrin and at the potential cost of the man's life, our recommendations were not carried out. It was the same old shameful story, that, because he was a withdrawing alcoholic, no hospital would admit him, and besides, who would pay his bill? In any event he lay around in the same flop house for another five days, and came back to us in only slightly better shape. We could not send him back again. It was obvious that he was both physically and psychologically sick and that he needed treatment.

With the help of his social history, we began to learn a little bit more about this fellow. When he came to us he was homeless, an alcoholic, a little bit younger than the average homeless alcoholic who tends to be over 50. He was born into a home where his father, a professional bacteriologist, was a man who was "sorta hard to get to know." Not only he, but his brothers and his mother's brothers, almost without exception, were also alcoholics. His mother, a professional person as well, was also out of the home most of the time. Having been born into this kind of home situation as the oldest son, he wound up at an early age, twelve or thirteen, long before he was ready, becoming responsible for taking care of his younger brothers and sisters.

When he was about 15 years old, this boy's father died. Since he was an alcoholic most of his life, the boy probably had no relationship with him at all. Two years

(Continued on page 6)

A feature designed to help you keep posted on developments in the field of alcoholism.

RALEIGH, N. C.: The NCARP and the N. C. Department of Mental Health have moved their offices to 2100 Hillsboro Street. The post office box number, 9494, will remain the NCARP's correct mailing address.

CHAPEL HILL, N. C.: Dr. Harvey L. Smith, director of the Institute For Research in the Social Sciences at the University of North Carolina in Chapel Hill, has been appointed director of a federally-financed two-year state-wide study of mental health needs. The study is aimed at developing specific, long-range plans for comprehensive state and local mental health programs in North Carolina with emphasis on services in or near each county. It will cover the needs for a complete range of mental health services to adults and children and will include alcoholism. The North Carolina Mental Health Council will be responsible for the study, with Dr. Smith serving as director of the project.

NEW YORK, N. Y.: The National Council on Alcoholism has announced that National Alcoholism Information Week will be held December 1-7 this year. The NCARP and local alcoholism programs throughout the state will join in observance of this occasion and special publicity will be sent out to focus pubic attention on one of the nation's most serious health problems—alcoholism.

CHARLOTTE, N. C.: Charlotte will be the site of a two-year pilot study on counseling as a means of rehabilitating the alcoholic placed on probation by the courts. A new probation officer experienced in counseling has been hired by the N. C. Probation Commission for the project. Under the proposed probation program, persons charged with public drunkenness would be given the option by the courts of being released to a probation officer rather than serving a prison sentence. One of the key aims of the program is to work with the courts and the alcoholic probationers to help the alcoholics to help themselves—to make them self-respecting, self-supporting citizens. It is hoped that the study will produce enough valuable information and good results to warrant expansion of the counseling system on a state-wide basis in the future. Reverend Joseph Kellermann, director of the Charlotte Council on Alcoholism, has been a key leader in the movement to obtain a full-time rehabilitation counselor to work with public drunkenness offenders.

RALEIGH, N. C.: Beginning October 1, all four of the state's mental hospitals will begin admitting alcoholic patients. At present only Dorothea Dix Hospital in Raleigh and Cherry Hospital in Goldsboro admit involuntary alcoholic patients. The new policy includes both of these hospitals plus John Umstead Hospital at Butner and Broughton Hospital at Morganton. Patients committed by court order will be hospitalized in the institution in their home district. The Alcoholic Rehabilitation Center at Butner will remain the principal treatment facility for voluntary patients, but the four mental hospitals will be authorized to handle such cases if space is available.

DURHAM, N. C.: The semi-annual meeting of the Alcoholism Programs of North Carolina will take place at the Jack Tar Hotel in Durham on November 8. The Durham Council on Alcoholism, headed by executive director Mrs. Olga Davis, will serve as host for the meeting.

RALEIGH, N. C.: The NCARP together with the Greensboro Council on Alcoholism and the Industrial Management Club of Greensboro is planning a series of five two-hour sessions on various aspects of alcoholism beginning on October 15. The sessions, which will be held on five consecutive Tuesday nights, will include discussions on Alcoholics Anonymous, Al-Anon and the alcoholism program at Western Electric, among other subjects. It is hoped that these programs will be the stimulus for establishing a continuing AA program in the major industries in Greensboro. NCARP associate director Dr. Norbert L. Kelly and the medical director of the Alcoholic Rehabilitation Center at Butner, Dr. Norman A. Desrosiers, will conduct sessions.

WIESBADEN, GERMANY: The 11th annual European Roundup of AA groups was held recently in Wiesbaden. Frankfurt and Rhine-Main AA groups joined with the Wiesbaden AA's to play host to loners and other groups throughout Europe and the United States.

WHITE SULPHUR SPRINGS, W. VA.: Three broad goals and twelve specific tasks to help the South in its campaign against mental illness and mental retardation were presented to the Southern Governors' Conference by Governor Terry Sanford of North Carolina, chairman of the Southern Regional Education Board, in August. Called a "platform for progress", the report, entitled "Commitment to Health", was prepared and sponsored by the Southern Regional Education Board's Commission on Mental Illness. The first of its kind for any region in the nation, it culminates a year's work by the Commission in formulating the goals for mental health in the South.

Three fundamental goals for the future are set forth in the report: 1) Preventing mental disorders before they start; 2) Providing the best care for the mentally ill that we know how to give, with special emphasis on early, uninterrupted treatment and care close to the patient's home; and 3) Helping people strengthen their emotional "muscle" which is needed to combat daily problems and occasional serious crises.

The report also puts forth several specific tasks for professional leaders which are necessary to reach those three goals. Some of these include better training of personnel; more extensive research; and improved services for diagnosis, treatment and rehabilitation, with more mental health services within easy reach of all citizens.

later, when he was 17, his mother, suicidally depressed, took her own life, allegedly due to "lonesomeness." The fact that he lost both parents before the age of twenty will ring a bell with the sociologist because, according to studies that have come out of Rutgers, New York, Chicago and Detroit, over 50 per cent of the homeless alcoholics—the skid-row type of individual who has no home—lose one or both parents before the age of twenty. So far then, it seems, this boy had the cards stacked against him from the beginning. But this is not the end of his story.

He was a shy fellow—the individual who got pushed around, bullied too much—never the aggressive athlete. Despite all, he finished high school and went out into the world at the age of 18. He headed first for the service, trying to get into the Army, but was refused because, shortly after his mother died, he contracted tuberculosis and had to spend a number of months in a sanatorium. He further developed, at the same time, a syndrome, called Menieres Syndrome, which is a particularly diffuse sort of condition where it is postulated that the inner ear is affected giving symptoms of dizziness and fainting spells. A psychological component is speculated in the etiology of this condition and in this case must be considered seriously.

For an 18 year old boy to get tuberculosis makes you begin to wonder about just how poor his physical condition was. Some things that are known concerning the psychological state of persons with tuberculosis, especially in view of this boy's age and background so far, tend to fit in with this patient's main problem which is exhibited in the *symptoms* of homelessness and alcoholism.

To get back to his story, the boy did not get into the institutional life of the Army where he would have had a clean bed and three meals every day. What did he do? It was in the mid-thirties. The country was just staggering out of the depression. The CCC Camps were in full operation. He was refused by one type of institutional life, the Army, but sought, and finally got into a similar type of institutional life, the CCC Camp. By now he was almost 20. and a recovered tuberculous patient.

Now, you ask, what about his drinking? When did it start? Right after his mother died, of course. Why? He was profoundly depressed at this time. And believe me, children do get depressed. Rene Spitz showed quite well that even babies get depressed when separated from their mothers and sometimes go on to die from what used to be called Morasmus. So our patient began to drink, and found that the pains of loss and guilt over the imagined punishment visited upon him were temporarily anesthetized by the chemical properties of alcohol. This was the beginning of a consistent pattern which has continued to this day.

During this time he made some attempt to adjust to adult life, but, and this is one of the cardinal characteristics of the homeless alcoholic, he failed. He became involved in abnormal sexual practices, both homosexual and heterosexual, but even this type of interpersonal transaction was too stressful for him. Consequently he abandoned these practices and made an attempt at marriage. Meanwhile he obtained a job at which he was able to function for 18 solid years. The job, however, was a simple, repetitive, non-demanding, general office boy job which was way below his intellectual ability.

It can be seen, then, that things were not going right for him at an early age. The problem of regression and function at an earlier age started early. Psychiatrically it could be

said also that he had experienced a prolonged grief reaction when his mother died which kept on growing.

His first marriage lasted about eight years and came to an end because he developed impotency. He divorced his wife, which was another loss, when she bore another man's child. At this juncture when he was badly hurt and again rejected by a female figure, his drinking increased in a vicious spiral of descent and the ever-increasing vortex—which is so characteristic of the deterioration of the homeless alcoholic—got a little tighter.

Second Marriage

He tried marriage again a couple of years later. This marriage lasted for about five or six years, but this time his wife left him because she could not meet nor accept his excessive demands for being taken care of. Near the end of this marriage, he began to get involved with the law. In April, 1962, for example, he was apprehended for driving under the influence, not of alcohol, but of paraldehyde. The spiral continued. The next arrest was for a more serious offense—hit and run driving—but fortunately no one was seriously hurt. It was immediately after this episode that his wife left him and he really began to hit the bottle, staying anesthetized to a fairly heavy degree.

He finally got to the point where he began to think that life was no longer worth living and began to threaten suicide. By this time also he had become homeless. He was living in a cheap boarding house in one of our larger cities, getting his meals out as he could. He came by a little money from odd jobs and planned his intake of alcohol so that it would last over as long a period of time as possible. But it was not enough. He was finally sent to a state mental hospital as a suicidal individual after an abortive attempt in October, 1962.

He went to the hospital scared, looking for some place for protection. Although this might seem illogical, he blossomed in the institutional setting. He became one of the best kitchen helpers at the hospital. When the time came for him to be released, he almost had to be "kicked out" and, although he was not depressed at the time, was back on the bottle even before he got out of town. The person who came to get him could not control him. This trend continued for several months until a friend, an interested friend of earlier years, saw what was happening to this fellow. He was a homeless alcoholic who had to have alcohol, who needed alcohol, and who was very sick. He was taken in hand and arrangements were made to get him to the Center. His appearance and eventual admission already has been discussed.

This particular individual was chosen as the basis for this discussion because he is a living person who illustrates a number of points about the homeless alcoholic. The two major points, however, are well summed up in a statement by chief Justice Murtaugh of New York City who wrote: "The homeless alcoholic is really a public health problem because he is a seriously physically ill individual as well as a seriously emotionally ill individual."

The first point to be made is that these individuals are, for the most part, medically actually quite ill or potentially so. This young man illustrates quite well what can happen to an individual who doesn't eat, sleep, exercise or do any of the necessary things that go into building a relatively healthy body. He was tubercular and potentially can become so again should his physical health deteriorate and his body's defense mechanisms break down. The

causative organism still resides in his lungs as an opportunist quite ready to reactivate in the presence of a favorable environment. The general debility, physical exhaustion, vitamin deprivation, and plain starvation that is the result of a liquid diet of alcohol notoriously lowers the body's resistance to infection.

Another thing that must be kept in mind in dealing with the homeless alcoholic is that he is chronically undernourished, and has experienced a longer or shorter period of vitamin deprivation. The doctor is, therefore, faced with the possibility of the actual existence in mild form of all the diseases occasioned by lack of adequate food and vitamin intake. There will be both extremes, of course—the Falstaff type of drinker who eats well, even voraciously, with his drinking, or the individual who has been drinking for several weeks without a morsel of food. The latter individual in a very real way constitutes a medical emergency.

Not too many years ago, for instance, the disease of pellagra was not the rare entity it is today. In my own experience I have seen only a few residual cases on the custodial ward of the mental hospital. It is my feeling, however, especially in view of the number of dermatitides seen at the Alcoholic Rehabilitation Center, that after many prolonged binges the disease of pellagra in early form is seen. Again and again skin eruptions on the exposed areas of the skin of patients who come to the Center are seen in combination with gastro-intestinal upsets and sometimes minimal hyperesthesias in the extremities— all early signs of pellagra. Because of this observation of what are felt to be the early signs of pellagra, all patients who come to the Center are placed on a vitamin preparation that contains the entire group of water-soluble B group as well as C to aid in tissue repair. Early cases of what used to be called beriberi, in modern terms polyneuropathy, are not infrequently seen. This disease, also due to a chronic lack of a specific vitamin B compound, namely Thiamine, finds its expression in malfunction of the peripheral nervous system. Affections of sensation in the lower legs appear most commonly in the burning feet syndrome and other neuralgic type pains. The upper extremities can be affected as well. The latest case that comes to my mind was a gentleman who exhibited the phenomena of the involuntary abduction of his left arm which persisted for several days toward the end of a three week binge. Appropriate vitamin therapy brought fairly prompt remission.

Some of these patients may exhibit a more advanced picture of starvation in a form of liver disease which is not cirrhosis but a condition of yellow fatty infiltration. Cirrhosis is the end product of any inflammatory change that occurs in the liver. It is the scarred and healed condition where the liver contracts, not enlarges as most laymen seem to think. The enlarged tender liver that some alcoholics exhibit on physical examination is not necessarily a cirrhotic liver but rather is an inflamed liver due to the effects of carbohyrate starvation and depletion. It is essentially a form of hepatitis. A forceful reminder of this condition and an exact parallel to the condition is to be seen in the pictures of prisoners of war who came out of German prisoner-of-war camps. Can you remember what they looked like? All skin and bones, but with huge bellies. That belly was practically all liver, and that is the extreme form of what is being described. The condition is present to

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ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

The Predicament of the Alcoholic's Wife

BY THE WIFE OF AN ALCOHOLIC

This article was originally given as a talk at the Summer School of Alcohol Studies, University of North Carolina, June 9-14, 1963. A companion talk, *The Predicament of the Alcoholic,* was given by a recovered alcoholic at the same session.

I finally recognized that the most important thing I could do was to change myself and stop fighting my husband.

THE predicament of the alcoholic's wife and family is one that few people can understand unless they have lived through the very trying experiences caused by drinking and have come through them with a little understanding of the illness of alcoholism. I shall try to tell you what we were like, what happened, and what we are like now.

My husband and I both were the youngest children in a family of four, but I was possibly more spoiled than my husband since there were seven years between my age and that of my youngest sister. I was very happy as a child and loved my family dearly. When my father had three children in college and I wanted something, he and mother would say, "Be patient. When you are ready to go to college, you will have anything you want." I was content to wait and daydream.

The "big depression" was my first big disappointment. I went to college but did not have everything I wanted. I wondered each month if I would be able to stay for the entire year. After my freshman year, I went to business college and then worked for two years out-of-state. My family decided that if I must work they wanted me back in North Carolina, so I returned. It was then that I met my husband.

We were married in 1935 and were considered an ideal married couple. My husband was going to law school at night. We were happy and the future looked bright. We were social drinkers. All of our friends drank and we felt that it was the smart and sophisticated thing to do. At first, like so many young married couples, we couldn't afford to buy whisky, but—fortunately or unfortunately—our friends were able to supply it. We were considered good drinking companions and fun to be with, so we were never without invitations to parties.

My husband went into the Army a few years after we were married. After he was commissioned, I joined him at a large navigation base and we were there for the duration of the war. We very quickly found ourselves in a drinking crowd—parties every night and the entire week-end. My husband was commandant of cadets and had a fine military record. Our best friends were high ranking officers and we had it made.

After the war was over, we came

back to North Carolina and found ourselves trying to adjust to civilian life again. My husband was drinking more and more, but I was not too concerned about it. After all Bill had always been able to command any situation, and I thought he would be able to adjust in time.

Suddenly, we were in a very good financial position and our partying and drinking came to be a way of life. We had no children so we could always have a party or go to a party. Bill's work demanded that we entertain a good bit so we were members of all the good clubs—and that is where he could always be found—on the golf course or at the bar of either the country club or the downtown private club.

Bill's drinking increased. He was in and out of hospitals with nerves, hypertension and high blood pressure, but no doctor ever told him that he should stop drinking or that he was drinking too much. It was always, "You must relax more." He would quit drinking for several months and then start again, drinking more and more each time. I became worried and frightened at what was happening, but I didn't understand it.

Disappearing Acts

Bill would pull disappearing acts and I wouldn't know where he was for days. The only thing that was important to him was his bottle and his game of gin rummy. He was gambling constantly and drinking to stay alive. His employers became upset and talked to me about the situation. I tried to reason with him, to make him understand what he was doing to his health, his reputation, and that he would surely lose his job if he continued—but this did not faze him. He was very resentful and arrogant, informing me and his employers that he would handle the situation just as he wanted to.

My security was threatened and I was terribly worried. Like so many wives, I tried to put on brakes. I refused to go to drinking parties. I stopped inviting people in. I stopped drinking with my husband. I nagged, fussed, threatened. I did everything I could think of—all of it wrong. There was no communication between us. We were strangers living in the same house, each trying to control the other.

I was consumed by resentment, anxiety, fear. I had lost control of a situation. What could I do to regain control? How could I get Bill to drink like I wanted him to? What were people thinking? I was terribly embarrassed. A good reputation was very important to me and this just didn't happen to nice people. I was confused and lied about circumstances and conditions, trying hard to hide the fact that things were not right at our home.

Bill was drinking twenty-four hours a day. He had been asked to resign his job and was trying to get started in a new business. While Bill was making enough money playing gin rummy to pay his club membership and bar bill, I was working to keep things going, paying the bills, and trying to make people think that everything was all right.

I have always been a conservative person and was able to hold on to money. While my husband was throwing his away, I was saving all that I could get my hands on. And when I found out that he was several months behind with our house payment, I was able to pay off a very large loan. This gave me a little feeling of security—I did have a home, a very nice and lovely home, that was paid for. Bill would never be able to drink that up. After work, I would call Bill at his club and tell him that I was ready to go home

and he would say, "Call a taxi, you have plenty of money." But I never did: it was much cheaper to ride the bus.

Because my thinking was distorted and my nerves overwrought, I held fears and attitudes that certainly were not sane. Having been told by my friends how patient, long suffering and good I was to assume the roles of mother, nurse, guardian and breadwinner, I began to develop a self-sufficient and smug feeling of rightness. I thought I was perfect and that I had been dealt a very bad hand. I was filled with self-pity. Why had this happened to me? I had done no wrong. My friends told me that I was a fool. They would say, "Why don't you divorce him? You can support yourself and make a life for yourself."

I don't think that I had any particular feelings against getting a divorce. but I hated to think that I had failed in my marriage. I was no quitter. I was determined to fight it out to the bitter end. After all, Bill and I were both intelligent people. We had been happy at one time. Something was wrong, I didn't know what, but surely we could work this thing out.

Sleepless Nights

There were many sleepless nights —nights that I just lay in bed trying to build up enough strength so that I could go back to work the next day. It was not unusual for Bill to stay out all night, drinking and playing cards. and then sleep most of the day. There were many times that I wanted to give up and run away from it all, but I knew that as long as I was alive, I just couldn't. Even in the depths of my despair, I believed that somehow, somewhere, there was a way out of the predicament in which I found myself, but I was sick and frustrated and my mind was so confused that I could not think. I prayed, night and day, a very childish prayer: "Please God, make Bill stop drinking." I never thought to pray: "Please, God, give me understanding and wisdom. Help me to see myself as you see me."

Things continued to get worse. I was at the breaking point, and one Sunday morning it happened. I was dressed to go to church, which is just a short distance from our home, but I thought I would drive because Bill had discovered that he was out of whiskey and wanted to go to the club to get more. We had a terrific fight. I told him that if he left to pack and leave for good. This is just what he did. He decided to go to Florida, stay with his brother, and get a divorce.

I was very much upset. I knew I had done wrong. I had a long talk with my minister who had talked with both Bill and me on several occasions. He advised me not to go to Florida, but to wait. I remember that he also said not to feel guilty—that I had done the best I knew. Yes, I had tried, but I was mixed up and emotionally and mentally sick, too.

Bill and I became reconciled and I went to Florida and we came back together. Then the rat race really began. Bill was in the driver's seat. He was important. I had gone to Florida and brought him back. His drinking was constant. I honestly thought that he was losing his mind, and I was fearful for my own life at times. I was at the end of my rope. Bill's sister who is only two years older than he had been in Alcoholics Anonymous since she was 33. I asked her to come and try to help Bill. She came, a picture of serenity and peace, but Bill would not listen. It was the same old story. He could manage his drinking and stop at any time. She could not give me much hope. She said she had seen

people have to get to skid row before they came back, and sometimes they never did. She was convinced that Bill believed in God, so she did have hope for him. She advised me to forget Bill and think only of myself—that I had to continue to live and could not be responsible for Bill's life. She also told me that I would get something to help me if I would go to open A. A. meetings.

I went to A. A. and these people introduced me to the idea that alcoholism is an illness that could happen to anyone. I continued to go to A. A. meetings and felt better. Then one morning, my husband threw in the towel. He said that he wanted to go to the hospital and get straightened out and then he would start going to A. A. I went with him to open meetings and thought I was helping him with his problem, but I still did not realize that I had some changes to make within myself. My attitude was that everything would be all right now that Bill had found A. A. and I was happy. There was nothing wrong with our life but Bill's drinking problem, I thought, but I had much to learn.

I was a very spoiled, willful, self-centered and domineering person, but I did not realize this. I did not stop to examine myself. How could my husband find lasting sobriety when I felt that I was so perfect? Alcoholism is a physical, mental and spiritual illness and it affects the wife as well as the alcoholic.

Bill was not happy but I was too blind to see what was happening. Then one night, seven months after being in A. A., we had an argument and he started drinking again. This time he was like a wild man. He ran me away from home, asked our minister out of the house, destroyed some furniture and denounced God.

I left home late that night. This was it. We could never make a go of it. I felt that I had been the last mile, and now I had no regrets. My husband wanted me to come back home several weeks later, but I told him I would never consider returning unless he stopped drinking and went back to work. One night I decided to ask him to come over so that I could tell him I was going to have a lawyer draw up separation papers. He drove over and when I saw him I realized that he was a very sick man. He had been staying at home for a month drinking and trying to stop and trying to go to A. A. meetings. Instead of telling him about the lawyer, I told him that we wanted to help him, that we would do what we could. He said he was willing to do anything that we suggested.

We admitted him to the Alcoholic Rehabilitation Center at Butner at the recommendation of the Veteran's Hospital where we first went. He stayed twenty-eight days and I could tell by his letters that he was thinking better and receiving the help that he needed. When he came home, I knew that he was better, but I had learned a lot during that time, too. A staff member at the Center realized that I needed help, also, and counseled with me for several months. She taught me that alcoholism makes family members sick as well as the alcoholic. I tried to learn from her and am still learning each day. At her suggestion, I started going to Al-Anon where I have also learned a lot through the sharing of experiences and strengths with other non-alcoholic family members.

It has not been very easy for either of us these past three years, but we can see improvement in each of us. Bill has come through a number of trying experiences and disappointments with more stability each time. He still has depressions but

(Continued on page 15)

The author, Herman E. Krimmel, is director of the Cleveland Center on Alcoholism. His article is reprinted by permission from *The News*, a publication of the Cleveland Center on Alcoholism.

Learning the Rewards of Sobriety

BY HERMAN E. KRIMMEL

The alcoholic can use treatment effectively only when he finds rewards in sobriety.

THE therapeutic techniques used to help alcoholics achieve sobriety are elusive and difficult to define. We can say that counselling or psychotherapy are employed to good advantage, that acceptance and support of the patient as a human being instead of a drunk are crucial, and we can describe the supplemental role of Antabuse and tranquilizers.

But what actually happens to the alcoholic in his transition from chronic inebriation to sobriety? There are many who believe that this transition is essentially a learning process. The alcoholic must learn to live without alcohol and he will do this only if and when he is convinced that the rewards of sobriety outweigh those of intoxication.

The professional person who works with alcoholics must recognize the fact that drinking does have its rewards. It does, for example, provide temporary relief from the painful slings and arrows of outrageous fortune. A person discovers that he can banish the torments of anxiety, guilt and tension if he drinks enough. Eventually, he may use alcohol to avoid every crisis, large and small, and he is then a problem drinker or an alcoholic.

Inevitably, such deliverance from reality is brief and distress and disappointment follow as surely as night follows day. Nevertheless, drinking continues because the relief seems to be worth the suffering. As one authority has observed, " . . . it may well be that the immediate reduction in anxiety in some addictive drinkers more than compensates for the punitive attitudes of a wife or boss and the physical punishment involved in a hangover."

The alcoholic can use treatment successfully only when he finds rewards in sobriety. At the outset he faces conflicts of choice. One can almost hear him declaim: "To drink or not to drink, that is the question. Whether 'tis nobler in the mind to seek escape in scotch-on-the-rocks or to take arms in noble sobriety against a sea of troubles . . ."

This decision is not easy. As Dr. Elaine Kepner, psychologist at the Cleveland Center on Alcoholism, points out in a forthcoming paper: "Sobriety, like most behavior, is a pattern or chain of responses established through repetition over a period of time. To shape this pattern of sobriety, we break the process into a series of graded tasks, rewarding successive and closer approaches to the goal. Since new behavior is most effectively established by reward, we consistently reward those responses which fit into a pattern of sobriety."

The patient's initial step, which is simply a visit to the clinic, is rewarded by staff acceptance of him as a worthwhile human being and, obvious as this may seem, it is all-important to many alcoholics.

Relief from anxiety is a second reward. To quote Dr. Kepner again: "Alcoholics have experienced such prompt relief through drinking that they have neither the inclination nor the capacity to endure the intense anxiety accompanying the drying out period." This anxiety is expressed in restlessness, hyperirritability, hopelessness, remorse and guilt.

A patient who had been in and out of nursing homes sixteen times in one year said gratefully that the Center therapist was the first person who seemed to understand the tortures involved in the struggle for abstinence. "It's been hell for me this past week," he reported, "but it meant so much to know that someone knew that and cared. Maybe that's why I was able to stay dry without falling apart and, maybe with that kind of support, I can make it next week, too."

Frequently, the miseries of early sobriety can be alleviated by encouraging the patient to do something else, to find substitute satisfactions. These may be found in hobbies, physical recreations, community activities, intellectual pursuits, employment or, for those who are married, in re-learning the arts of being husband-father or wife-mother.

The creation of these substitute rewards frequently requires the cooperation of family and friends and they, too, may need help. It may be difficult to re-open lines of communication between an alcoholic and his family but it is necessary. Members of the family are indispensable in aiding the recovered alcoholic to resume normal responsibilities but experience has made them wary and they may impede rather than accelerate. However, the alcoholic must be able to anticipate these rewards of sobriety or his desire to get well may ebb and vanish.

The alcoholic must learn that, for him, drinking and its consequences are incompatible with his own goals and values. He must learn to abandon self-deception and to face realistically what drinking does to him. If it continuously blocks the path to those goals and values, he must give

up one or the other but he cannot make that choice until he clearly perceives the consequences and the alternatives.

In a clinic this awareness of consequences can often be awakened by the development of a drinking history with the alcoholic. It is a technique that requires the patient to examine his drinking behavior and its relationship to his daily problems.

One man, for example, came to the Center after he had been suspended from his job. At the outset he vigorously denied that drinking had the slightest relationship to his suspension. He was, he declared, a social drinker. A bit too much at times, possibly, but nothing serious. But the therapist insisted on discussing the drinking and the patient began to concede that there may have been some connection between weekend binges and consistent Monday absenteeism. And possibly drinking did have something to do with the fact that he had been passed over for promotion on several occasions. Other incidents were also seen in a new light. He had been "careless" recently during the installation of high power lines and the crew asked that he be transferred out of their group.

Slowly the light of awareness dawned. He saw that drinking could never be compatible with the goal of security and if he continued he would risk a job he enjoyed, a good salary and generous retirement benefits. This awareness was a long step toward recovery.

Call it training, call it education, call it a technique of reward and punishment. The label is unimportant. What is important is the realization that the successful treatment of an alcoholic seems to be based on *learning* principles. It should be emphasized that this learning process is gradual and demands repeated reinforcement.

THE PREDICAMENT

CONTINUED FROM PAGE 12

has learned how to react to them. For my part, I have realized that the best solution to any problem is to change your relationship with the thing that hurts. For a long period of time, I tried to put other people's lives in order according to my wishes. I tried to run the show, only to find that my ideas and suggestions were rejected. I can live only my own life, letting those around me do likewise. I finally recognized that the most important thing that I could do was to change myself, my own attitude, and stop fighting my husband.

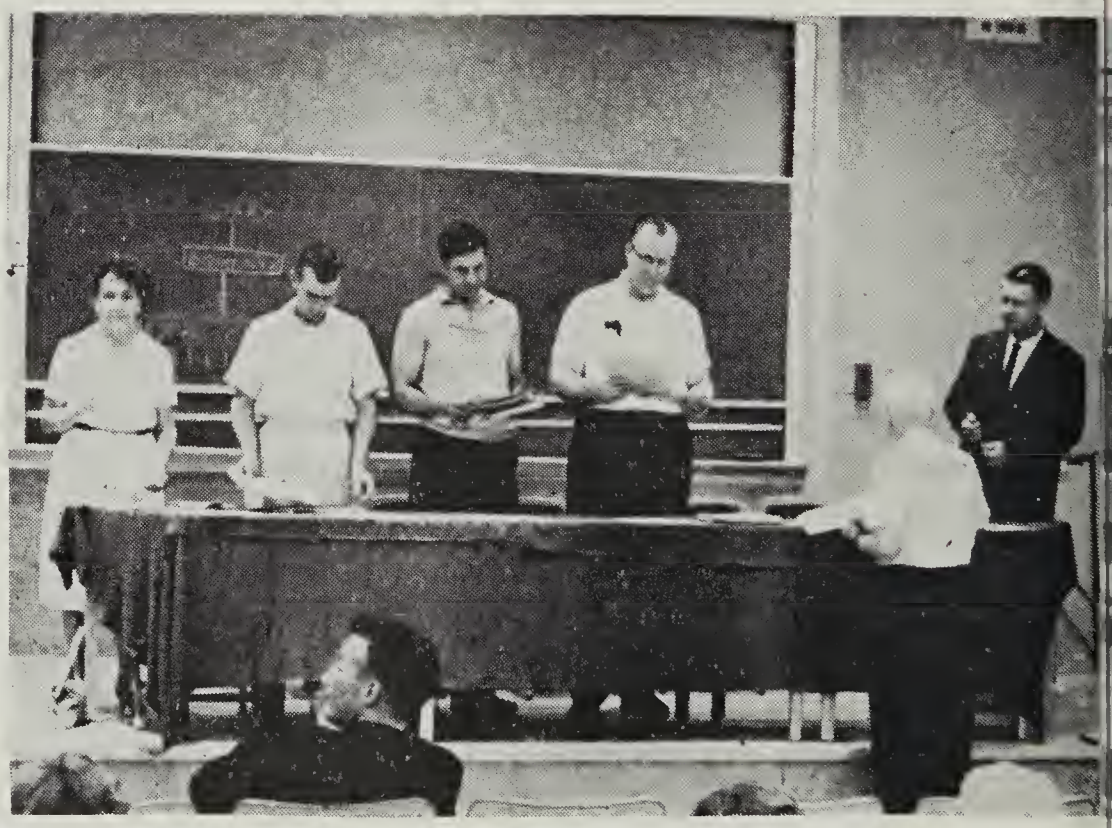
There are many adjustments to make. The partner of the alcoholic needs the A. A. program also. I was just as powerless over my husband's alcoholism as he was since I had failed in every attempt to control his drinking. I tried to manage Bill's life although I was unable to manage my own.

I found that I had so many shortcomings that the word, humble, took on a new meaning—patience and honesty with myself. I had to stop rationalizing and to face things realistically. I had to learn the truth about myself. I did not develop all the shortcomings in a day and lifetime habits are life-time jobs to correct. This task of reforming myself will take so much time that there will be little time left for me to take my husband's inventory or try to change other people. And when I have made some progress, I am amazed to see what has happened to those I love.

In our search to find a way out of our problems, through A. A. and Al-Anon, we are learning to understand ourselves and I am sure that we will find peace of mind, contentment and a way of life that will be satisfying to both of us.

The combination of teaching ability plus knowledge can produce effective alcohol education for youth, the goal of the 1963 Summer Studies on Facts About Alcohol conducted by the North Carolina Alcoholic Rehabilitation Program and five North Carolina Colleges. Some 156 public school teachers and prospective teachers attended the 1963 summer sessions. Around 90 additional individuals including law enforcement officers, court officials, social and public health workers, ministers and professional persons working in the field of alcoholism, as well as teachers, participated in similar courses on facts about alcohol and alcoholism at two other colleges. The seven sessions ranged in length from one to three weeks. East Carolina College in Greenville (right) had the largest attendance with 75 students. Dr. N. M. Jorgenson was the college coordinator.

A one-week course at the University of North Carolina in Chapel Hill (right) and a two-week course at Catawba College in Salisbury (below) brought in law enforcement officers, court officials, social and public health workers, ministers and professional persons working in the field of alcoholism as well as teachers.



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Half of the class of North Carolina College at Durham looks over literature and reference books on alcohol and alcoholism (above). On the right, students of the first Summer Studies on Facts About Alcohol to be taught at Winston-Salem State College, Winston-Salem, listen intently to a lecture.

Classes for the students of Western North Carolina College at Cullowhee were held at the Industrial Education Center in Asheville (left). St. Andrews Presbyterian College in Laurinburg (below) had the longest course — three weeks.

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some degree in all alcoholics.

The drinking individual also is usually in a state of chronic dehydration. A little known effect of alcohol is to block the production of anti-diuretic hormone which is produced in the posterior pituitary gland at the base of the brain. The decreased production of this hormone results in the excessive excretion of water by the kidneys which are rendered unable to re-absorb the water necessary for maintaining the water balance of the body. We see a reflection of this in many patients coming to the Center. The specific gravity of their urine is remarkably low, sometimes hardly more than water. The condition is one of a temporary, reversible, diabetes insipidus.

Our patient had all of this. He couldn't eat; he had the dry heaves. His nervous system was chronically oversedated. The balanced activity of the nervous system is somewhat analogous to the swing of a pendulum. You do not push a pendulum off center and, on releasing it, have it return to dead center. When an oversedated nervous system begins to escape the anesthetizing effects of alcohol, it tends to swing, like the pendulum, over to the other side of uncontrolled hyperactivity. It is when this process of reactivation with a vengeance occurs that the patient begins to experience the uncontrolled shakes and tremors, auditory and visual hallucinations, as well as more serious convulsive seizures. All alcoholics learn very early that the best temporary amelioration of the morning after shakes and general malaise is to re-anesthetize their nervous systems. In one very real sense, when this occurs, the state of that individual is one of physiologic addiction.

The whole intent and purpose of going into some detail about the medical problems of the alcoholic is to impress you with the fact that the actively drinking alcoholic is a medically ill person, and is often an acute medical emergency.

The second major point to be stressed is that the homeless alcoholic is also sick psychologically. The young man we have discussed gives us a golden illustration of one of the major problems in the causation of the homelessness of some alcoholics —undersocialization. Straus, who has done a great deal of sociologic study of this group, points to this factor of early undersocialization as a consistent finding in the backgrounds of these men.

This young man never had a chance. From the very beginning his interpersonal relationships with the main person in his life with whom he should have identified as a man never really began. For example, he will say, "I can never have children," and yet nothing has been found physically to account for it. The real cause is impotence due to psychological causes. It is a beautiful illustration of the fact that he has not yet achieved manhood.

Going deeper into the history of this disheveled, unshaven, medically and psychologically sick individual begins to illustrate a diagnosis that is often missed by the physician treating these individuals. That diagnostic entity is depression. A great many persons who march across the general physician's doorstep are actually suffering from the psychosomatic complications of depression. Some estimates run as high as 50%.

One of the main things to look for in depressive reactions is a series of losses. Our patient, it will be recalled, at the age of 15 lost his dad. With his father gone, his mother committed

suicide two years later. With this in mind, you can begin to understand the tremendous amount of guilt the boy felt. Death is final in interpersonal relationships. It is the ultimate kicking out, the final boot—in this life at least—of the child out of the parents' life. Suicide of a parent writes this fact loud and clear in the child's memory.

It will be remembered that it was precisely at this time that our patient became ill with depression and tuberculosis. He suffered the loss of his health. Later you will recall, after having recouped his health to some degree, and making some attempt at marriage, he suffered another loss. There is probably no greater blow to a man's ego than to have his wife step out on him and to bear another man's child. In essence this was really a double simultaneous loss to him, the loss of his wife as well as the loss of a great deal of his male ego. At each juncture, his drinking increased.

In 1958 when his second marriage was about to break up, he developed appendicitis and had to undergo surgery. While he was recuperating, a young boy who was in the bed next to him died. He had gotten to know the boy slightly and learned that he was 18, the same age as he was when his mother had taken her own life. This experience produced a profound effect in our patient because it came too close to what his real wishes were when he was 18 and his last remaining parent gave him the ultimate rejection by destroying herself.

From that point on his drinking became uncontrollable. He had to stay continuously anesthetized in order to escape the intolerable feelings of guilt, self-destructive urges—in short, profound depression. He began to lose weight as a result of losing his appetite. He could not sleep. He lost interest in everything. He withdrew. He became a seriously psychiatrically ill person. The correct diagnosis of this man is that he was depressed, primarily, and that his homelessness and alcoholism were signs or symptoms.

The homeless alcoholic, because he has lost and lost and lost, is much more likely to be depressed to a serious degree than the average so-called addictive drinker. He is on the whole a much sicker person.

We have been talking about the "homeless alcoholic." What happens if this particular spiral continues? The answer is pretty obvious: continuing physical, psychological and sociological deterioration occurs. Individually the patient cares for nothing. He cares for no responsibility and no longer feels any responsibility towards society, or even towards himself. He doesn't care any more and he becomes remarkably like, if not equal to, the simple schizophrenic.

In this discussion we have been tracing the historic development of an individual who has arrived at the social status of homelessness and who, at the same time, exhibits the symptoms of alcoholism. Our purpose in so doing has been to make clearer an understanding of some of the underlying factors that went into the development of his present state, as well as to indicate some of the medical and psychologic implications of that state. It is hoped that this presentation will play some part in developing further understanding of this type of individual and to further facilitate an acceptance of him as a person in desperate need of care and treatment. It is to the credit of the Association of Flynn Christian Fellowship Houses that they have recognized the great need of providing at least a home for the "homeless alcoholic."

Inventory "On Loan"

A family doctor has been lending me some copies of *Inventory*. My husband is an alcoholic. I find all the articles in your magazine helpful and would like to be placed on your mailing list.

Anonymous
Polk County, N. C.

Thanks For Inventory

Inventory has been coming to our house now for several years and it's about time we came up with some "thank you" words and fill you in on what we do with it. Being an active AA member, I use much of your material in our weekly meetings. The articles are well written and are readily adaptable to most any group set-up. It is my privilege to go into the alcoholic ward of the county hospital each week where we conduct an AA meeting. Here again we make good use of some of your excellent articles. Our copy is often passed on to the clergy and to the people in the hospital as well as members of the group having a "go" at it. When our copy comes home, it's a bit "dog-eared" but we still maintain a file. Thank you for keeping us on the mailing list and for the help we get from the publication.

Anonymous
Omaha, Nebraska

Resource Material

As a long time reader of *Inventory* and an active member of AA, I find much valuable material in your publication. I have used it extensively as a basis for lectures and talks for many years. The July-August, 1963 issue is outstanding and I only wish I could, at my own expense, have several articles reprinted to distribute. This being impossible, would it be asking too much to have a dozen copies of the July-August issue of *Inventory* mailed to me?

Anonymous
Coronado, California

Helpful In Teaching

I am working on my master's degree in medical-surgical nursing at the University of North Carolina; I plan to teach medical-surgical nursing in a collegiate program after graduation. I would appreciate being placed on the mailing list for copies of *Inventory* which I feel can be helpful in my teaching.

Beverly L. Fussell, R.N.
Chapel Hill, N. C.

Thesis On Alcoholism

I am a student of Fordham University's School of Social Service and am interested in exploring the field of alcoholism. It is my desire to select an aspect of this area and develop it in the format of a thesis which is required for the MSW degree. I would appreciate any information which you feel would be fruitful for such a thesis, and would be grateful for any material which would open new doors for a specific topic within the realm of alcoholism. I have been exposed to your journal, *Inventory,* and found it very informative.

Gerald P. Kinzler
New York, New York

LEARNING SOBRIETY

BY A. W. FRASER, M.A.

ASSOCIATE DIRECTOR OF TREATMENT
ALCOHOLISM FOUNTAIN OF ALBERTA

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MANY alcoholics achieve and maintain periods of sobriety through treatment at hospitals and clinics. At the time the alcoholic terminates treatment, he understands the nature of his illness, realizes that moderate drinking for him is an impossibility and as he is firm in his intentions not to drink again, feels he needs no further treatment. Several months later, he is drinking again.

What has happened to his conviction that he must never again take even a single drink? Or to his recognition that he is an alcoholic and does not, cannot, react to al-

The alcoholic must keep in constant use the "new learning" he acquired during treatment or it will be lost.

Principles of Learning Theory

1. We retain knowledge, information, and attitudes which we use, and forget those we don't use.

2. Old imbedded learning is retained even though consciously used very little, while that recently acquired is lost quickly if not used.

3. If something gives us immediate pleasure, we remember it easily and will probably repeat it quickly and often, thus imbedding the learning firmly.

4. Things we learn easily are retained longer than those we learn with difficulty.

cohol the way non-alcoholics do; that to drink at all inevitably means drinking to disastrous excess? In view of past bitter experiences, how could he ever again believe that he could control his drinking?

It may seem puzzling, but it really isn't. Examining some simple principles of a learning theory stated at the beginning of this article will enable us to understand why the alcoholic slips.

For example, we do not forget, nor will we ever forget, simple addition and subtraction, because these were drilled into us as young children, and we use them every day. However, we soon forget high school algebra because it was "newer" learning (learned later in life), and probably not used after we left school. We will never forget our own or our brother's names but how about someone we were introduced to last week, but haven't seen since?

We can recite half a dozen nursery rhymes that we learned as children, but we forget a telephone number we memorized yesterday.

Let's relate these learning principles to the alcoholic and his drinking. What is the "imbedded learning," the information, attitudes, and beliefs about drinking and alcoholism, that will be well retained and used automatically to guide his behavior?

1. Society has taught him, since he was old enough to understand, that alcoholism is a sign of a shamefully weak character, and that anybody who amounts to anything can handle his liquor and will not get drunk if he doesn't want to.

2. His personal experience, first as a youngster by observation, then as an adult by participation over a good number of years, has taught him that alcohol gives immediate pleasure (even though this will now be followed by distress.)

"Even after many years of
reinforce knowledge
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In treatment the alcoholic gains new learning about drinking. This new learning is strong immediately after treatment, but will quickly be lost if he does not use it constantly for a long period. He learns that:

1. Alcoholism is an illness that develops in a cross-section of the population, regardless of will-power, strength of character or personality.

2. He is alcoholic and, however adequate he may prove himself to be, he should never again use alcohol.

This is not only new learning, but also difficult learning — difficult learning which took years of bitter teaching to achieve. If the new learning is used frequently over a sufficiently long period, it will begin to imbed itself and will eventually become a firm part of the alcoholic's total personality. If it is not continually reinforced and kept strong by regular use, it will quickly be lost and the old learning will reassert itself. Further, the attitudes, beliefs, and behavior of the majority of the people around him will tend to reinforce and reactivate the original learning. Thus after many years of sobriety, the recovered alcoholic should continue to reinforce the knowledge and conviction that he is alcoholic and should not drink at all.

What can the newly recovering alcoholic do to insure that his new understanding is not forgotten? The surest resource available to him for this purpose is Alcoholics Anonymous. It takes time and personal effort to benefit from the AA program, but there is nothing as important to the alcoholic as maintaining complete sobriety for the rest of his life. Therefore, he should not hesitate to

sobriety, the recovered alcoholic should continue to and conviction that he is an alcoholic and drink at all."

put as much, if not more, time into insuring his sobriety as into insuring that he is successful at his job or in his family life. He may have to travel five, ten, or fifty miles to a meeting; he may have to visit several groups to find one he likes; he may feel for the first half dozen meetings that he can't "buy" a lot of what he hears (he should remember that it took years of punishment and loss before he could "buy" the fact that he was an alcoholic); he may feel strange, uncomfortable, self-conscious for a while at AA meetings. Despite all this, he should not give up AA and try to get by on his own.

AA has helped hundreds of thousands of alcoholics to achieve and maintain sobriety; many of these had personal difficulties and problems similar to his own. AA is as much a standard prescription for the continuing recovery from alcoholism as is an iron tonic a standard prescription for continuing recovery from anemia. The person who won't take a prescribed and proven medicine because he doesn't immediately like the thought or the taste of it is being foolish. If he keeps on taking it, he will at least get used to it and may even get to like it. (After all, who enjoyed the taste of whisky at first —it took time and regular practice to develop a liking for that taste!)

Regularly, once a week, sometimes more often, the alcoholic is investing time and effort into maintaining his sobriety by reviewing and refreshing his new learning about himself and his condition.

AA provides him with fellowship and a feeling of "belonging." He finds company and companionship with others who, like himself, are not "drys," but people who don't drink. When he starts the recovery process, most of the alcoholic's friends are just drinking companions. Few of them will be around to provide him with company when he is no longer drinking. Further, his fellow AA members know from their own experience the problems that face the recovering alcoholic. He will find acceptance and understanding in an AA group that he won't find in any other group. This doesn't mean that he is going to like every AA member that he meets. He may find that he dislikes a few, but this will apply to any group that he joins.

AA provides activity, something to do to fill those long, restless hours that used to be occupied by drinking. There are also Al-Anon meetings for the wife and social evenings for the couple.

By talking to other AA's and by listening to them, he learns that other people who seem to be folks he can respect and like have had the same kind of embarrassing and shameful experiences, and gotten into the same difficulties that he has. Also, he sees what happens when someone with a period of sobriety decides to try drinking again. This by itself is a powerful deterrent.

The AA program revolves around twelve steps of recovery. These are twelve guides to obtaining life-long sobriety and not only help the alcoholic maintain sobriety, but also affect positively his personal life. No "don'ts" are involved, but instead twelve suggested "do's." No one can "graduate" from AA as having successfully completed the course, nor

can anyone fully complete any one step except the first one.

Twelfth-stepping takes a number of forms, one of which is going out in response to a call for help from alcoholics who are still drinking but want to quit. The AA member who is just starting to do Twelfth Step work is told that what he is doing is primarily for himself and only secondarily in the hope of helping someone else.

The recovering alcoholic tells his own story to the sick alcoholic, thereby reviewing and refreshing in his own mind the difficulties, the suffering, the awful hangovers, the feelings of despair and fear which once troubled him.

He sees before him a living example of the way he himself often used to be. He hears rationalizations about the causes of drinking and drunkenness similar to those he once used. He encounters the blindness (or denial) of the active alcoholic to the relationship between his drinking and his problems and to the necessity of giving up drinking completely. This provides powerful reinforcement of his new learning.

After the AA member has learned a bit about the AA program and way of life, he may undertake sponsorship of a new member. This new member may be someone whom he has twelfth stepped, but it need not be. Good sponsorship entails much more continuing time and effort than does twelfth stepping and should not be undertaken lightly nor unless one is prepared to contribute a good deal toward helping a new member hang on to his sobriety.

Sponsorship is providing company, understanding, and encouragement to a struggling new member and it means not only getting him to meetings, but staying with him during the meetings. It usually involves daily contact by phone and over cups of coffee for some time, and being available at all times. It means listening to his problems, his fears and frustrations and helping him to believe that they really will decrease as his sobriety lengthens. "Sponsoring" activity, although involving a much greater effort to help others, is still primarily carried out for the sponsor's own good. He is learning to extend himself, to be concerned about others, to give up some of himself without expecting reward.

Sometimes the sponsor falls into the trap of expecting the reward of the new member's continuing gratitude and admiration, or of regarding the new member's success as a badge or tribute of his efficiency as a sponsor. If the new member displays ingratitude or lack of appreciation, or is unable to maintain sobriety, the sponsor may become angry, hostile, or punishing toward him, or may swing to the other extreme and become over-anxious about or too protective of the new member. Either way the sponsor gets too stirred up, too personally involved and thus endangers his own sobriety. An alcoholic should be in AA for some time, long enough to absorb some of its basic teachings, before attempting sponsorship work. However, providing good sponsorship to a new member is one of the most rewarding of AA activities.

Alcoholics Anonymous and the Alcoholism Foundation are not connected in any way. However, all Foundation patients are encouraged to join the AA group of their choice. The Foundation's view is that AA is the most effective long-term therapy for the alcoholic. It provides fellowship, acceptance, and understanding and, if the alcoholic regularly attends AA meetings, his new learning about drinking and alcoholism is reinforced until, in time, it becomes an imbedded part of his personality.

The JUDGE and the Alcoholic

BY JUDGE WILLIAM H. BURNETT

PAST PRESIDENT
NATIONAL ASSOCIATION OF
MUNICIPAL JUDGES

The revolving door will never cease revolving until we take time to look at the people that we so expensively capture and confine.

Reprinted by permission, this article originally appeared in *Focus*, a publication of the Washington State Department of Health.

IN the area of alcoholism which most concerns the judges in the municipal or city courts of the nation, the emphasis must be on the derelict or skid-road drunk. This group constitutes (1) Only a small percentage of the total alcoholics within the nation and (2) A great many persons with defects other than alcoholism.

Judges in this field are prone to approach this problem with a peculiar pessimism; for, day after day, they deal with the weakest and most completely inadequate segment of our society.

For six years, I have presided over the General Sessions Division of our Denver Municipal Court into which come the drunks, the vagrants, the prostitutes, the participants in disturbances, breaches of peace, affrays and various types of unorthodox and strange conduct found offensive to society—the literal dregs of humanity who are scooped up from the dark alleys and gutters of a big city at night and paraded in front of the judge the next morning as if he had some magic cure for human degradation.

The most perplexing of all of these are the drunks—those sick, dishevelled, zombie-like creatures frequently as much dead as alive, living in a half world of unreality, looking at the judge and the court sometimes trustingly and at other times with hostility, but, most frequently, with complete disinterest and disdain.

In this environment, judges have been driven to extreme frustration—in part because we have been handed the two accepted tools of criminal penalization—the fine and the jail sentence—to deal with what is primarily a social and medical problem. We have found ourselves dissatisfied with these tools both on philosophical and practical grounds.

On the other hand, we are cast in

the role of the bully trampling down and further degrading those within our society who are already the weakest and most inadequate among us—which grates on our sense of fairness—but, on the other side, we find ourselves frustrated by the realization that we do not protect society by the prevention of law violations in this regard, which, of course, is the basic function of all law enforcement. Little wonder we find ourselves gathering in groups with the hope of reorienting ourselves and gaining a fresh approach.

It might be wise, initially, to consider some of the complexities of our problem. Over-simplification can hardly get us on the right track—yet, that is always our tendency.

Just the simple practice of describing our "drunk" docket under the general term "alcoholics" is an example.

Actually, I wish it were that simple. Alcoholism is bad enough, but that's only part of it. For the most part, we deal with humans whose inadequacy would be, at most, only partly corrected by sobriety. Intellectual and emotional inadequacy is a relative thing depending upon the society in which a person finds himself; but the gap between the "haves" and "have-nots" is widened in a highly complex society such as ours.

In the thatched roof, grass-hut, primitive society, the gap between the rich man and the pauper, the genius and the idiot, the king and subject was not so great—a few more coconuts or a few more wives, perhaps, but little else.

But things are different now. When I was in school, it was thought that a high school education was important for success; then, a college education became essential to compete; and, today, we think in terms of post-college specialization. Moreover, we bring our children along much faster

"Show me the community that will show you a community

nowadays, grade for grade.

What does this mean? For one thing, it means that those who fall by the wayside—those who just don't have it, or who haven't benefited from the proper environment will fall far behind, indeed. The gap is great, and, by the indiscriminate jailing of the inadequate we tend to make it greater.

Sociologists have pondered why we keep a larger percentage of our population in jail than any other civilized nation. I suspect a good part of the answer lies in the growing cultural gap between the adequate and the inadequate, those able to compete and those unable to compete, those who can socialize and those who are drastically under-socialized.

The real planners of our day, and of the future, will be men with practical solutions for bridging this gap.

Another over-simplification is our tendency to lump the inadequate all together under the humane classification of sick or ill people.

These terms certainly fit in many instances; but we should realize that this "sickness" reflects a lack of capacity in the first instance or an inadequate growth, or both.

Obviously, we are dealing here with something far beyond the general concept of illness or disease. This very fact of inadequacy of people leads us to another over-simplification which contains its own trap. We tend to throw up our hands, acknowledge our weakness, and cry for an "institution."

We are not exactly sure what the institution should be like, or what it

akes time to supervise a prisoner it releases and I

where re-arrest is far less likely."

should do, or how long people should stay there, or its cost to society in relation to the results achieved, but still we say, "Some day, some one is going to do something for those poor so-and-sos."

Don't get me wrong! I am not especially opposed to institutions for alcoholics. They may fit many needs and, certainly, in most instances could better serve, and more humanely serve, than the institutions which they replace—the jail, a la the "revolving door." But too much reliance on the institution itself should be carefully examined.

Most of those with whom we deal every morning have been over-institutionalized already and the institutional patterns developed have accentuated rather than diminished their anti-social behavior.

These so-called "dregs of society" with whom we deal are not alone the products of bad homes or bad environments. They are usually that. But more, they have been handed on to us and reconfirmed as products of institutions.

The military service, the merchant marine, the correction school, the work camp, the CCC, the railroad gang, the mission and jail—and you could name many others—all have in common the all-male, barracks-type existence, basically desocializing in nature, in which ties with normal society play no part; and those individuals who might have developed an adjustment to normal society have been sidetracked.

These institutional groups provide a protective, but monotonous routine; and even the fullest schedule is broken by nights, weekends, and layoffs with the fullest opportunities to drink. Drink is often the preoccupation of these sub-societies, and their conversation is filled with talk of drink. The imagery and love of drinking are built up by talks and stories. Fantasy around future drinking episodes serves to reduce the monotony of humdrum jobs and to alleviate the dull routine of sexual deprivation and loneliness of the all-male group.

I speak especially of the all-male group because they account for so great a share of the persons with whom we judges deal. Drinking becomes the veritable symbol of manliness and group integration.

We would be well advised to direct our attention not to confining people in institutions, but to integrating them in society to whatever extent may be possible. We would also be well advised to try to prevent the incipient alcoholics and beginners in the field from falling into the institutional pattern which is so hard to break.

I am not suggesting that alcoholism is not an important part of our problem. Ninety percent of the general ordinance violation docket comes before municipal court judges because the person's habits relate to alcohol. I am fully aware that we deal with thousands of alcoholics.

I merely mean that alcoholism, as we see it, must be placed in perspective with the other problems and considered with them; or, otherwise, solutions will be painfully disappointing.

It seems to me it would be wise to

consider the most effective long-range plans and also the practical steps which any judge may take immediately. In this regard, why not start in our own courtroom and with our own attitude? Actually, haven't we sort of taken the position that we should get this sorry mess over with so that we can get on with the "real" business of court?

Did you ever wonder what the "drunks" themselves think of our courts? I once had a unique opportunity to find out. Several years ago our State Supreme Court handed down a decision upsetting the practice of handling ordinance violations as civil matters and requiring that they be handled as criminal matters. After this decision, scores of drunks and vagrants, who were in jail under the old procedure, retained a couple of enterprising lawyers to bring habeas corpus actions for the lot of them. In court, each was called upon to testify and, as might be expected, they didn't confine themselves to the issues of the habeas corpus action; but proceeded to give all their grievances against municipal court treatment, in Denver and throughout the land.

Guess what they resented most? The fact that they weren't really given a chance to discuss their case with the judge—that they were herded through. I was forced to admit that there was considerable validity to their complaint.

When I first came on the bench, we had been following the practice of letting the bailiff do the arraigning before the court convened, leaving the judge only the responsibility to impose sentence. We allowed not more than one-half hour for arraigning the entire group, which frequently numbered twenty to forty individuals. Obviously, there was little time for individual consideration. Now, here they were in court testifying that all they wanted was a simple chance to speak to the judge face to face. I swore then that I would never knowingly permit a defendant to go forth with his penalty with the feeling that he hadn't really had the opportunity to speak in his own behalf.

These are frequently not pleasant people to talk to. The odor of liquor gets rather bad; and I confess that, at times, I would have hated to have been required to take a breathalizer test upon leaving the bench. Many are "wise guys" and, often, the defendant is likely to be "shooting an angle" with the judge. The point is that sometimes it is the little things that are important to these miserable people. They have been dragged lower than anyone else in our society; and we, in the courts, should take care not to drag them any lower than we have to.

Educational Effort

A basic educational job can be done subtly each morning by the court. It should be made obvious, by words and available literature, that the judge considers many persons before him as ill and in need of treatment.

In our Denver court, I usually made it a practice to start off the "drunk" docket with words something like this, after, of course, advising the parties of their basic legal rights:

"It may be that some of you feel that you are not here primarily because you are law violators, but because you feel that you have a serious drinking problem that you would like to do something about if you could. I would just like to say this to you—that if any of you do feel this way—this Court is most anxious to help you in any way possible. There are a number of things that you can do. There is treatment available for you if you sincerely

want it. Among other things, I would like to tell you that there is a group of people who feel the same way as you do, who meet right here in this courtroom every Monday night at 8:00 o'clock. This we call the Denver Court Honor Class, and any of you who are interested are most cordially invited to meet with us."

We also suggest that they examine the slips of paper which have been handed to them, which also do a little bit of an educational job. The point is that, even if a person never attends a meeting, or never sees a doctor, or never seeks treatment, at least he has the opportunity for a little bit of education; and he realizes that the judge, misguided though he may be, suspects that the person may be sick or in need of help. This attitude is in stark contrast to the one which grants the "floater."

Many a time the defendant has said to me, "Judge, give me a suspended sentence and I'll leave town." I always reply that it really makes no difference to me whether he leaves town or not, but that somewhere, sometime, he is going to have to face his problem, and it might as well be here and now; and, if he wishes to do so, we would be glad to help him face it.

Those whose illness is obvious, either physical or mental, should be directed to receive medical-psychiatric attention. I think these services are available in most communities throughout the nation, although their use by the judge may be had only with considerable difficulty. So long as we continue to handle these people exclusively in jail, however, no other institution or agency will be eager to jump into the field.

Next, I would recommend that every court in the country either establish a court-sponsored group of alcoholics, such as the Des Moines and Denver Court Honor Classes, or have a related Alcoholics Anonymous group under the direct sponsorship of the court.

I claim no credit for this idea. Judge Ray Harrison, of Des Moines, Iowa, who is an alcoholic with many years of sobriety and, who, during his drinking days, was in his own jail a number of times, has come up with this approach.

The format is very simple. The judge merely invites persons coming before him to meet with him on one night a week. We usually don't call these meetings Alcoholics Anonymous meetings for the simple reason that, at the inviting stage, we know many people are not willing to call themselves alcoholics.

We don't want to scare them away. Moreover, an honor class can still have the benefits of Alcoholics Anonymous and, at the same time, retain more freedom to move in other directions.

Any judge, wishing to start this type of program, would be well advised to enlist at least two alcoholics, who have recovered through Alcoholics Anonymous and who are dedicated, to help organize and sponsor the group. The secret of success will be the faithfulness and regularity with which the meetings are held. At our first meeting in Denver, only eight persons were present; now, the average attendance exceeds one hundred. No meeting has ever been cancelled, even when the meeting night has fallen in the midst of a storm or on a holiday such as Christmas or New Year's.

At the meeting, we talk about sobriety and some of the practical problems in achieving sobriety and, after it's all over, we have refreshments consisting of coffee and doughnuts. Surprisingly enough, the gang attending takes a collection which even pays for the refreshments.

We laugh a lot and the judge usually comes wearing an old sport shirt. They call the judge by his first name, and, if anybody has a good joke to tell about a judge (and they always do), they can hardly wait until the judge gets there to tell it in his presence. For them, this is great fun; but, you see, something more is happening here than just humor. For here, they are meeting in the courtroom, which, in Denver, is in the Police Building, with the judge present—all the symbols of the hated and mistrusted authority around about them—the very place where they have reached their lowest point of degradation; and, here they learn to laugh and find friendship.

Letter From Judge

As the court's contribution, the sponsoring judge gets off a weekly "court letter" which is addressed to each individual who attends. (Each person present signs his name and address on an envelope leaving it in the courtroom for the court letter to be inserted and mailed.) This letter really isn't so much (the judge makes a few comments on the meeting, and on any other subject which he feels might be helpful), but, for some of these people, it is the only mail they receive. It means that somebody cares.

I am firmly convinced that mental health can, under certain conditions, be mass-produced; frequently, less expensively and more effectively than it can be spoon fed.

Please know that I don't suggest this as a cure-all for the problems that we have discussed, but, even for those incapable of grasping a program of sobriety, at least they have a rapport with the judge. Success in this field is not always determined by making a person a one hundred percent church-going, tax-paying citizen. Sometimes success comes by way of staying out of jail longer, or holding a job longer, and of trying harder.

Some say the person who is only partially an alcoholic is like the woman who is only slightly pregnant, or the man who is just barely dead. Even so, if a person is motivated to stay sober and work for one month, and, during this time, to make some contribution to society, both society and the individual have benefited far more than if he had merely been confined to jail during this period of time. After all, the purpose of all penalization is to protect society and we, as judges, must ourselves be judged primarily on how well we accomplish this mission.

The experiences in Denver and Des Moines lead me to b e l i e v e that drunken arrests can be cut by at least one-third, and, further, that the drunk jail population can be substantially diminished through this simple effort on the part of the judge. I don't know how you could get a better bargain. After all, it costs three dollars a day just to keep a fellow in jail. Moreover, in this approach, at least we try to keep them in society rather than to prevent f u r t h e r under-socialization through un-needed confinement.

In a similar vein, let me pass on to you the ideas of Judge Keith Leenhouts of Royal Oak, Michigan, who has found a rather unique probation system using, for the most part, voluntary probation officers. He has mobilized the leading citizens of his community: the doctors, the lawyers, the ministers, the professional men of all types, the more able personalities within the community to serve as volunteer probation officers. How does he get them to work? Very simple. He has so many volunteers that he can assure them that their case load will not exceed one or two. As you know, probation usually falls

down because the size of the case load prevents the necessary individual attention. Quite possibly, this young judge is one of the true pioneers who is discovering a way to bridge the gap between the adequate and the inadequate in our society. There are many other approaches motivated by the same general principles as our Court Class and the Royal Oak Probation System.

Many courts have a quick and direct liaison with Alcoholics Anonymous and with other agencies meeting welfare needs of indigent persons. In some cities, a special noonday Alcoholics Anonymous meeting is held each day for the benefit of prisoners who have received suspended sentences. Other judges have specifically required attendance at prescribed AA meetings, sometimes with rather striking results. Still others specifically require attendance at special clinics or informational centers. Some communities have the benefit of half-way house facilities. This wonderful idea has never really been given a full chance. Some courts have attached clinics for immediate evaluation; others have the benefit of state-supported clinics closely assigned to the court. The inventive judge will use the facilities which are available and seek their improvement.

As we go further in this field, we will probably reach the conclusion that the evaluation clinic would be the most valuable medical aid to the court, so that in some way those individuals could be discovered who would be most likely to respond to the limited treatment facilities that are available.

A good example of progress in this field is the proposal of the Maryland Commission on Alcoholism that all convicted drunks be tested in a simple and concise manner. This can usually be done quickly and will, in most cases, determine the likelihood of a person's successful response to treatment facilities available. But, even if this ideal condition were reached, we are still faced with the undeniable fact that only a small percentage of our docket would be segregated out for treatment. Indeed, the more serious cases of inadequacy would be left with us.

For those who remain, life's special challenge: To find a niche for them in our society where their lives can find meaning. To the extent that we cannot find this place for them outside of confinement, we will, of course, frequently be called upon to confine them. But, even here, we might use our influence along the lines that have been so successfully developed in many states. We might as well face the fact that for these people the old county jail is as antiquated as the "one-horse, open shay." Even for these, we should think in terms of regional work houses and work farms, under the concept of minimum security and maximum contribution to society. As a society, we needn't feel nearly so guilty about the necessity of confining inadequate people as that of releasing them under conditions of worse misery and less opportunity than where we found them.

The "revolving door" will never cease revolving until we take time to look at the people that we so expensively capture and confine. Show me the community that takes time to supervise a prisoner it releases, and I will show you a community where re-arrest is far less likely. But, what have the judges to do with this? Just this. It is more than just a coincidence that the communities who have made the greatest progress in this field have felt the leadership of a judge who is interested. Who else in our community is so likely to lead in this field?

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ASHEVILLE—

**Educational Division, Board of Alcohol Control;* Don Dancy, Educational Director; Parkway Office Building; Phone ALpine 3-7567.

†*Mental Health Center of Western North Carolina, Inc.;* 415 City Hall; Phone ALpine 4-2311.

BURLINGTON—

‡*Outpatient Clinic;* Alamance County Hospital; Hours: Wed., 9:00 a.m.-4:00 p.m.

BUTNER—

‡*Aftercare Clinic;* John Umstead Hospital; Hours: Mon.-Fri., 9:00 a.m.-4:00 p.m.

CHAPEL HILL—

†*Alcoholism Clinic of the Psychiatric Outpatient Service;* N. C. Memorial Hospital; Phone: 942-4131, Ext. 336.

**Orange County Council on Alcoholism;* Dr. D. D. Carroll, Director; 102 Laurel Hill Rd.

CHARLOTTE—

**Charlotte Council on Alcoholism;* Rev. Joseph Kellermann, Director; 1125 E. Morehead St.; Phone: FRanklin 5-5521.

‡*Mecklenburg Aftercare Clinic;* 1200 Blythe Blvd.; Hours: Mon.-Fri., 8:00 a.m.-5:00p.m.

†*Mental Health Center of Charlotte and Mecklenburg County, Inc.;* 1200 Blythe Blvd.; Phone: FRanklin 5-8861.

CONCORD—

†*Cabarrus County Health Department;* Phone: STate 2-4121.

DURHAM—

‡*Aftercare Clinic;* Watts Hospital; Hours: Tues. and Fri., 2:00-5:00 p.m.

**Durham Council on Alcoholism;* Mrs. Olga Davis, Executive Director; 602 Snow Bldg.; Phone: 682-5227.

FAYETTEVILLE—

†*Cumberland County Guidance Center;* Cape Fear Valley Hospital; Phone: HUdson 4-8123.

GASTONIA—

†*Gaston County Health Department;* Phone: UNiversity 4-4331.

GOLDSBORO—

‡*Outpatient Clinic;* Cherry Hospital; Hours: Tues. and Fri., 10:00 a.m. - 12:00 noon. Thurs., 2:00-4:00 p.m.

**Wayne Council on Alcoholism;* A. T. Griffin, Jr., Executive Director; P. O. Box 1320; Phone: 734-0541.

GREENSBORO—

**Greensboro Council on Alcoholism;* Worth Williams, Executive Director; 216 W. Market St., Room 206 Irvin Arcade; Phone: 275-6471.

†*Guilford County Mental Health Center;* 300 E. Northwood St.; Phone: BRoadway 3-9426.

†*Family Service Agency;* 1301 N. Elm St.

‡*Outpatient Clinic;* 300 E. Northwood St.; Hours: Mon. and Thurs., 5:00-10:00 p.m.

GREENVILLE—

†*Pitt County Mental Health Clinic;* Pitt County Health Department, P. O. Box 584; Phone: PLaza 2-7151.

HENDERSON—

**Vance County Program on Alcoholism;* Dr. J. N. Needham, Director; 2035 Raleigh Rd.; Phone: GEneva 8-4702.

HIGH POINT—

†*Guilford County Mental Health Center;* 936 Montlieu Ave.; Phone: 888-9929.

JAMESTOWN—

**Alcohol Education Center;* Ben Garner, Director; P. O. Box 348; Phone: 883-2794.

LAURINBURG—

**Scotland County Citizens Committee on Alcoholism;* M. L. Walters, Executive Secretary; 308 State Bank Bldg.; Phone: 276-2209.

MORGANTON—

‡*Aftercare Clinic;* Broughton Hospital; Hours: Mon.-Fri., 2:00-4:00 p.m.

NEW BERN—

**Craven County Council on Alcoholism;* Gray Wheeler. Executive Secretary; 411 Craven St., P. O. Box 1466; Phone: 637-5719.

NEWTON—

**Educational Division, Catawba County ABC Board;* Rev. R. P. Sieving, Director; 130 Pinehurst Lane; Phone: INgersoll 4-3400.

RALEIGH—

‡*Aftercare Clinic;* Dorothea Dix Hospital, S. Boylan Ave.; Phone: TEmple 2-7581; Hours: Mon.-Fri., 1:00-4:00 p.m.

†*Outpatient Clinic;* Rex Hospital; Hours Mon., a.m. and p.m.; Wed., p.m.; Thurs. and Fri., a.m.

†*Mental Health Center of Raleigh and Wake County, Inc.;* Wake Memorial Hospital; Phone 834-6484.

SALISBURY—

**Educational Division, Rowan County ABC Board*; Peter Cooper, Director; P. O. Box 114; Phone: 633-1641.

†*Rowan County Mental Health Clinic;* Community Bldg., Main and Council Sts.; Phone: MElrose 3-3616.

SANFORD—

†*Mental Health Clinic of Sanford and Lee County, Inc.;* 106 W. Main St. P. O. Box 2428; Phone: 775-4129 or 755-4130.

SHELBY—

†*Cleveland County Mental Health Clinic;* 101 Brookhill Rd.; Phone: 482-3801.

SOUTHERN PINES—

**Moore County Alcoholic Education Committee;* Rev. Martin Caldwell, Director; P. O. Box 1098; Phone: OXford 2-3171.

†*Moore County Mental Health Clinic, Inc.;* Box 1098; Phone: 695-7781.

WILMINGTON—

†*Mental Health Center of Wilmington and New Hanover County;* 1013 Rankin St.; Phone: ROger 2-8294.

**New Hanover County Council on Alcoholism;* Mrs. Margaret Davis, Executive Secretary; 211 N. Second St.; Phone: 736-7732.

WILSON—

‡*Aftercare Clinic;* Encas Station; Hours: Mon.-Fri., 8:00 a.m.-5:00 p.m.

†*Wilson County Mental Health Clinic;* Encas Rural Station; Phone: 237-2239.

WINSTON-SALEM

*†*Alcoholism Program of Forsyth County;* Marshall C. Abee, Executive Director; 802 O'Hanlon Bldg., 105 W. 4th St.; Phone: PArk 5-5359.

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